Colorado Medicaid
Nursing Facility

Colorado Medical Assistance Program

Nursing Facility Billing Workshop

UB04/8371

2009

April 2009

Colorado Medicaid
Nursing Facility

Presentation Overview

- NPI
- Web site
- Eligibility Inquiries
- Claims processing
- The UB-04
- Coding
- Benefits/Limitations/Exclusions
- Medicare/Other Insurance
- PARs
- NF PETI
- Redetermination Notification
- Managed Care

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National Provider Identifier (NPI)

- **The NPI was federally required and mandated on May 23, 2008**
  - As of May 24, 2008, electronic claims submitted without an NPI are rejected by the MMIS
- **All providers need to obtain and register their NPI**

Getting an NPI is free –
Not having one can be costly!

Colorado Medicaid Nursing Facility

National Provider Identifier (NPI)

Three ways to apply and obtain additional information:

1. The CMS web page: cms.hhs.gov/NationalProvIdentStand/
2. The NPPES website at: https://nppes.cms.hhs.gov
3. The enumerator at: 1-800-465-3203 (TTY 1-800-692-2326)

Getting an NPI is free –
Not having one can be costly!

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Register Your National Provider Identifier (NPI)

- Please refer to the *NPI Registration Help* by visiting: colorado.gov/hcpf ▶ Providers ▶ Provider Services ▶ News and Updates
- You may also register your NPI(s) and update enrollment information using the *Provider Enrollment Update Form* by visiting: colorado.gov/hcpf ▶ Providers ▶ Provider Services ▶ Enrollment
- Mail the completed form to the address on the form
- Please register your NPIs in the MMIS as soon as possible to avoid rejected/denied claims

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Use Your National Provider Identifier (NPI)

- For help on where to enter your NPI on 837 transactions, please refer to the *Companion Guides* by visiting: colorado.gov/hcpf ▶ Providers ▶ Provider Services ▶ Specifications

- Providers may use their NPI for all Web Portal transactions (batch and interactive) *with the exception of PAR inquiries*
  - ➤ Providers must continue to use their Medicaid provider number for all PAR inquiries

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NPI on Medicare Claims

- Medicare requires NPIs on all Institutional claims submitted electronically (i.e. 837I) to identify the primary providers (the billing and pay-to-providers)

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Health Care Policy and Financing's Web Site

colorado.gov/hcpf

For Provider Services:

Select the **Providers** tab on the gray menu bar at the top of the Department's Home page to go to the Providers page

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Provider Services

- From the menu on the left side of the page, select **Provider Services**

Hints & Tips:

Advanced Search option at the top of each page

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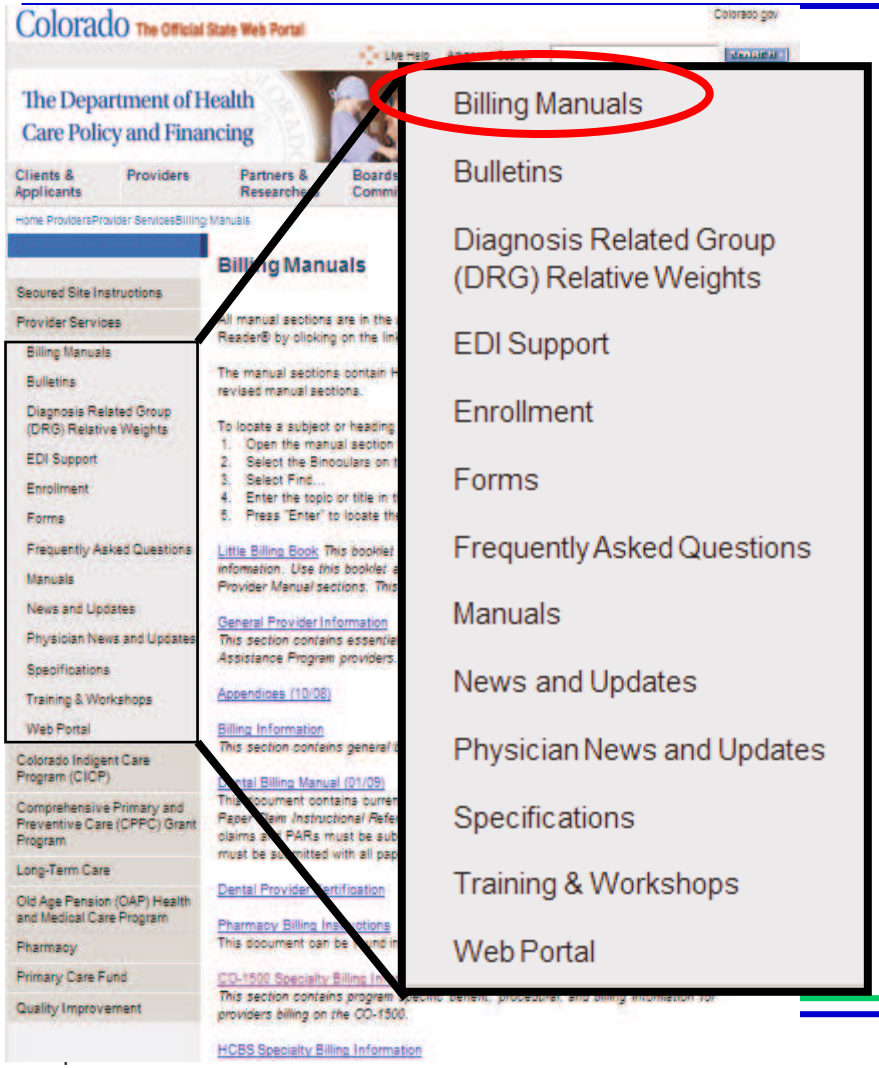
Billing Manuals Section



Sections of manual:

- General Provider Information
- Appendices
- Billing Information

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Provider Bulletins Section

- The Provider Bulletins Section ("Bulletins") is located under Provider Services
- All bulletins published since November 1998 are located on the Provider Bulletins "B" section

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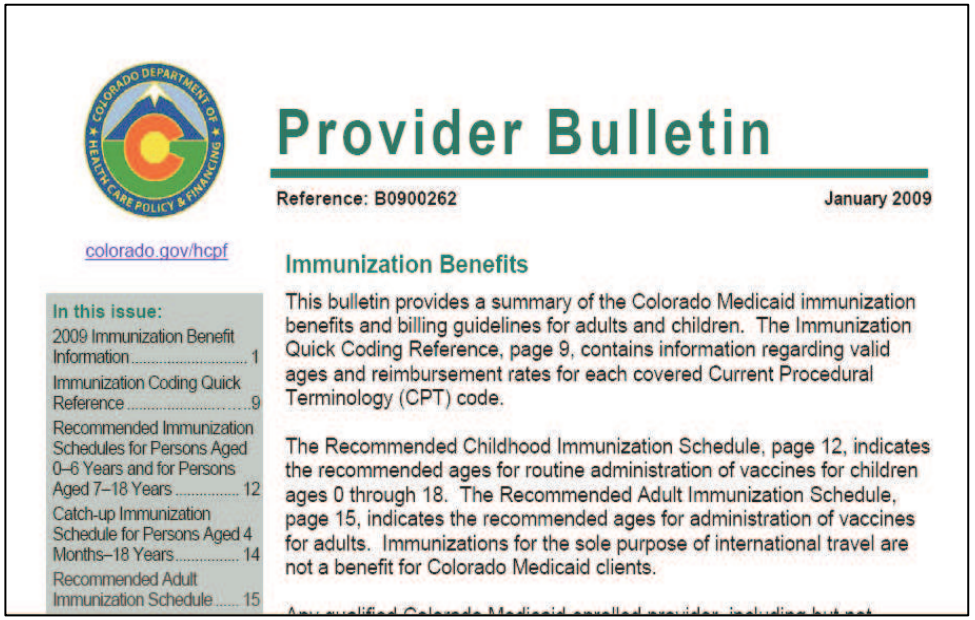
Bulletins

- Remind office staff not to throw away bulletins
- Keep bulletins & manual sections together in the same location



Provider Bulletin

Reference: B0900262 January 2009

colorado.gov/hcpf

In this issue:

Immunization Benefits

This bulletin provides a summary of the Colorado Medicaid immunization benefits and billing guidelines for adults and children. The Immunization Quick Coding Reference, page 9, contains information regarding valid ages and reimbursement rates for each covered Current Procedural Terminology (CPT) code.

The Recommended Childhood Immunization Schedule, page 12, indicates the recommended ages for routine administration of vaccines for children ages 0 through 18. The Recommended Adult Immunization Schedule, page 15, indicates the recommended ages for administration of vaccines for adults. Immunizations for the sole purpose of international travel are not a benefit for Colorado Medicaid clients.

- Sign up for electronic bulletin notification on the Web Portal at: (MMIS) Provider Data Maintenance

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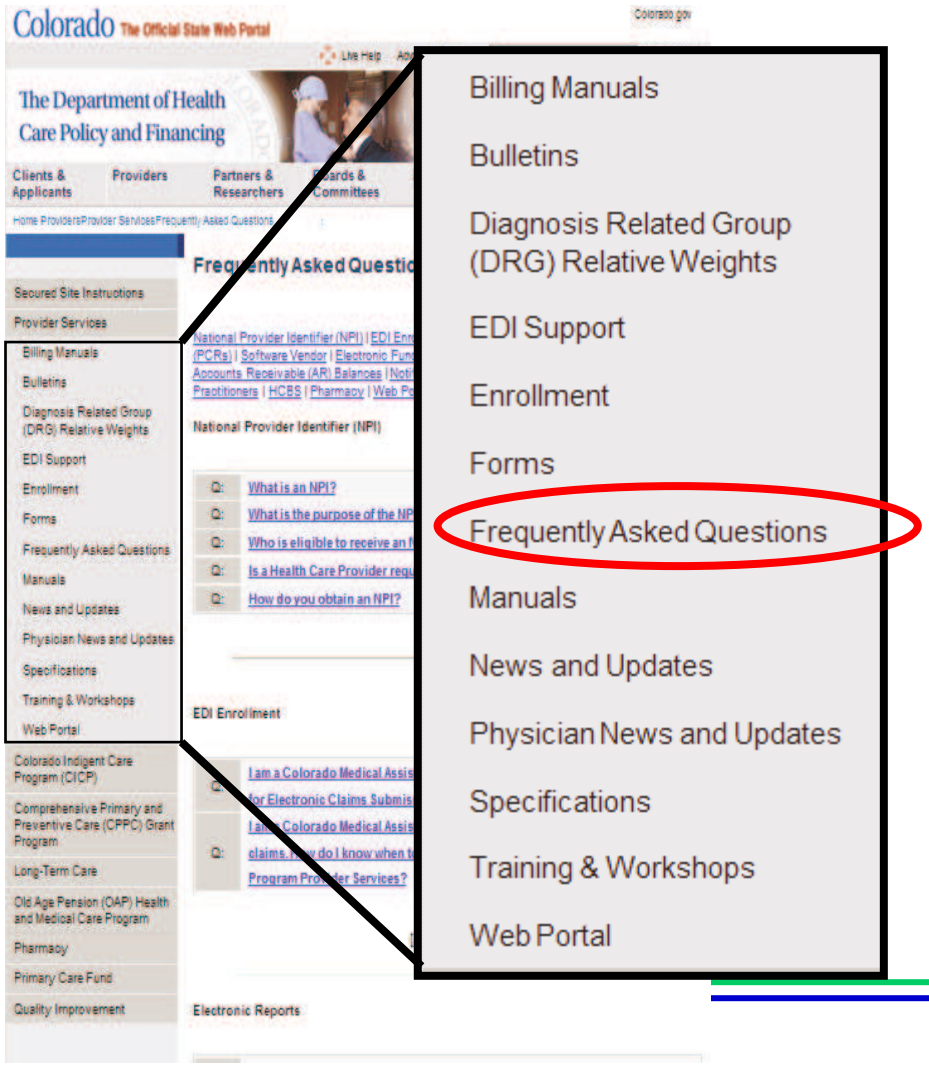
Frequently Asked Questions Section



- The FAQ Section is found under Provider Services
- The FAQ page contains questions and answers about:
  - NPI
  - Enrollment
  - Electronic Reports
  - PCRs
  - EFT
  - and more…

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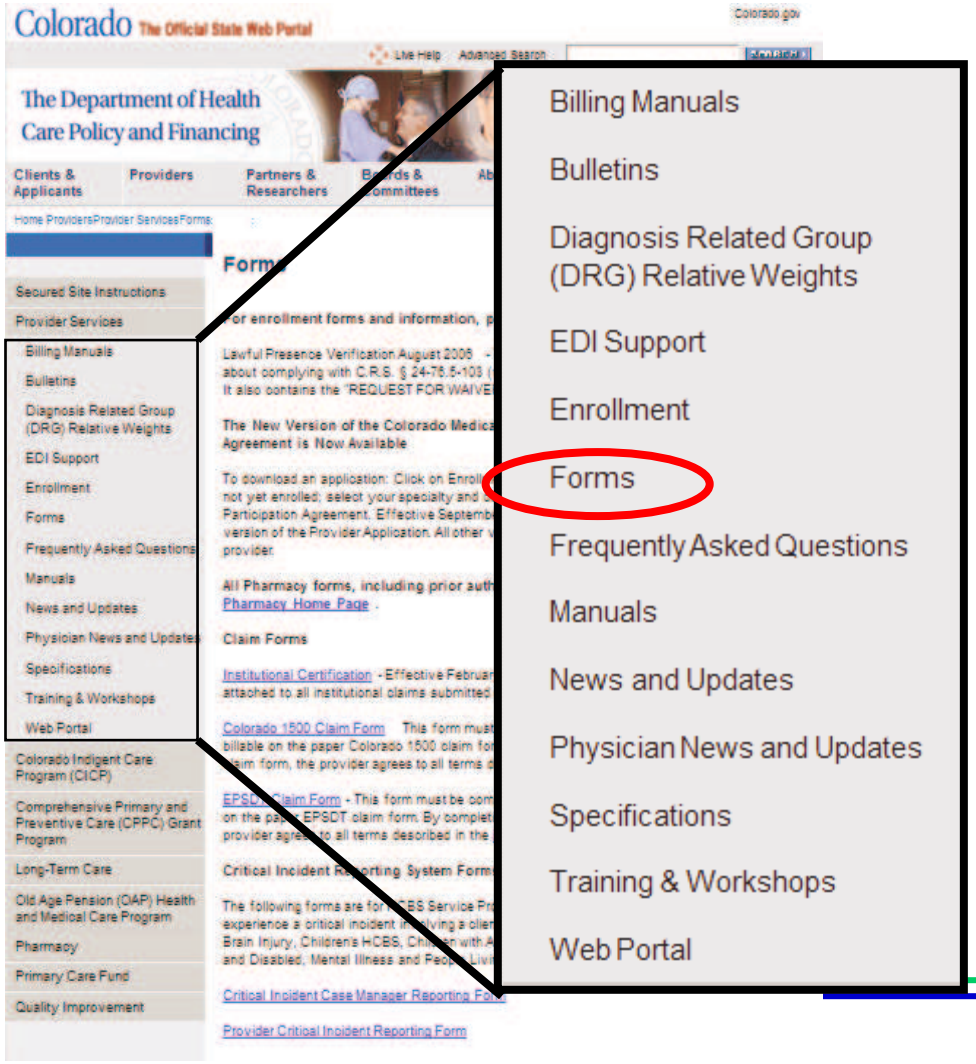
Forms Section



The Forms Section, found under Provider Services, contains:

- NF PETI
- Institutional Certification UB-04
- Other forms

Eligibility

- Verifying the client's eligibility is essential to being paid
- Eligibility verification information includes the client's:
  - Primary Care Physician (PCP)
  - Prepaid Health Plan (PHP)
  - Co-payment information
  - Third Party Liability (TPL)

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Eligibility

Ways To Verify Eligibility

CMERS
1-800-237-0044

Fax Back
1-800-493-0926

Medical ID Card (MIC) with Switch Vendor

Web Portal

- Always print and save a copy of eligibility verifications from Fax Back, your switch vendor, or the Provider Web Portal

Eligibility Type

- Understanding the client's eligibility type is essential to being paid
- Methods to verify eligibility type:
  - Call the county or eligibility site technician
  - Call the ACS help line and ask if the client has:
    - NF: High level program group LT and Program Aid Code MJ
    - HCBS: High Level Program Group LT and Program Aid Code M8

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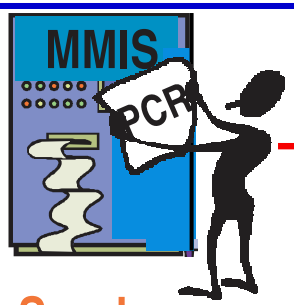
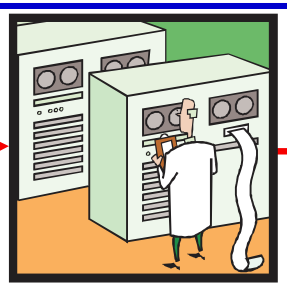
Payment Processing Schedule



Sunday

The fiscal agent processes the weekly payment and creates Provider Claim Reports.



Monday

Payment information is transmitted to the Colorado Financial Reporting System (COFRS).

COFRS

Tuesday

COFRS processes Electronic Funds Transfers (EFT) and warrants (checks).

Wednesday

The Department of Health Care Policy and Financing reviews payment information.

Thursday & Friday

Paper remittance statements and warrants are in the mail.

Friday

EFT payments are deposited in provider accounts at 12:00 am .

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Original Timely Filing

120 days from the date of service

Type of Service	Timely Filing Calculation
Nursing Facility; Home Health, Inpatient, Outpatient; all services filed on the UB-04	From the “through” date of service
Dental; EPSDT; Supply; Pharmacy; All services filed on the Colorado 1500	From the date of each service (line item)
Home & Community Based Services	From the “through” date of service
Obstetrical services professional fees Global procedure codes: The service date must be the delivery date.	From the delivery date
Services billed separately; additional services	From date of service
Equipment rental - The service date must be the last day of the rental period	From the date of service

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Original Timely Filing

120 days from the date of service

- Timely filing is determined by the **date of receipt**, not by the postmark
- Prior Authorization Requests are **not** proof of timely filing
- Certified mail is **not** proof of timely filing

120 Days:

DOS: Jan. 1, 20XX

Julian Date: 1

+120

Julian Date: = 121

Day 121 = May 1st

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Documentation for Timely Filing

60 days from date on the:

- Provider Claim Report (PCR) Denial
- Rejected Claim
- Returned Claim

- Use the delay reason codes on the 837I transaction per HIPAA Legislation
- Keep supporting documentation for auditing purposes

Paper Claims:

- Colorado1500 - Note the Late Bill Override Date (LBOD) and the date of the last adverse action in Remarks
- UB-04 - Enter Occurrence Code 53 and the date of the last adverse action

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Timely Filing for Clients with Medicare and Medicaid

Medicare Paid:

120 days from the date Medicare Paid

Medicare Denied:

60 days from the date Medicare Denied

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Timely Filing Extensions

The Timely Filing period may be extended when:

- Commercial insurance has yet to pay or deny
- Delayed notification of eligibility from client or county
- Backdated eligibility from county

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The UB-04

- UB-04 Paper Claim Submission
- UB-04 Claim Form
- UB-04 Certification
- UB-04 Billing Changes
- New UB-04 Specialty Manuals

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UB-04 Paper Claim Submission

- The UB-04 claim form is the only form accepted by the Colorado Medical Assistance Program to submit Institutional claims
  - UB-92 claim forms were no longer accepted as of June 1, 2008
  - Claims submitted on the UB-92 form will be returned without processing
- The UB-04 Specialty Billing Manuals are available by visiting:

  colorado.gov/hcpf ▶ Providers ▶ Provider Services ▶ Billing Manuals

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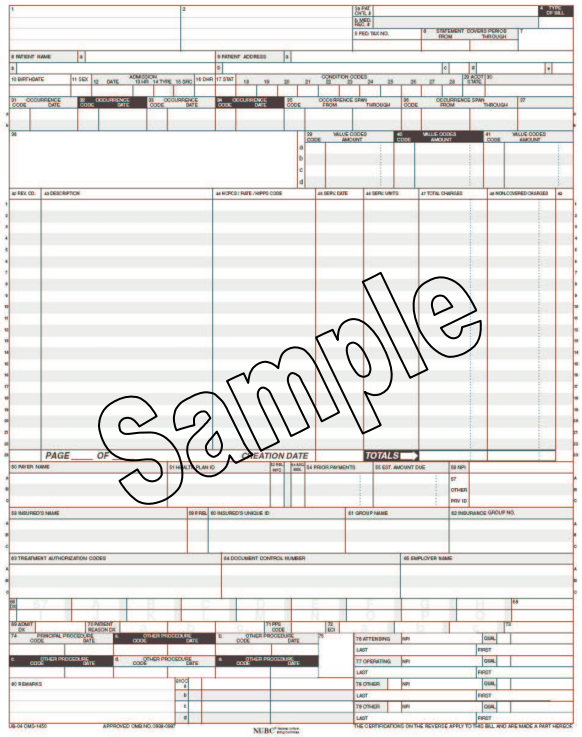
The UB-04 Claim Form

The UB-04 is the standard institutional claim form used by Medicare and Medicaid

- Where can a Colorado Medicaid provider get the UB-04?
  - Available through most office supply stores
  - Sometimes provided by payers



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The UB-04 Certification

- The UB-04 Institutional Provider Certification must be completed and attached to all claims submitted on the paper UB-04
- The Certification can be found in each UB-04 Specialty Manual
- The UB-04 Certification document can also be found by visiting:

  colorado.gov/hcpf ▶ Providers ▶ Provider Services ▶ Forms

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UB-04 Billing Changes

- Providers must use Value Codes on the UB-04 to indicate the following:
  - Value Code 31 - Patient Liability (Patient Payment)
  - Value Code 80 - Covered Days
  - Value Code 81 - Non-Covered Days

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UB-04 Billing Tips

- Do not submit "continuous" claims
- Each claim form has a set number of billing lines available for completion
- Do not add more lines on the form
- Billing lines in excess of the designated number are not processed or acknowledged
- Claims with more than one page may be submitted electronically

Colorado Medicaid
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Coding Reminders

Statement Covers Period (UB-04 Box #6)

- The "From" and "Through" dates must be within the same calendar month
- Example: Client is in NF from: 3/15/08 – 4/15/08
  - NF should bill
    - 03/15/08 through 03/31/08 **and**
    - 04/01/08 through 04/15/08
  - NF should **not** bill 03/15/08 - 04/15/08 on the same claim

Coding Reminders

- NFs are paid for date of admission but not the date of discharge
  - If a client is admitted and discharged the same date, that same date should appear as both the "From" and "Through" dates of service

Coding Reminders

- Using Medicaid billing codes incorrectly can result in losing important client data
- Nursing facilities should be careful not to code claims as discharges when the client is expected to return
  - A discharge can generate Occurrence Code 42 (This code can automatically end date Nursing Facility PARs)

Medical Leave Days

- When a client is in a nursing facility and has a hospital inpatient stay during the same month:
  - Only one of the providers may be reimbursed for a given calendar day
  - The nursing facility should bill days in the hospital, including the date of hospital admission, as medical leave days
    - The hospital receives payment for services on the date of admission without overlapping the nursing facility payment dates

Medical Leave Days

- Clients on medical leave from a nursing facility during any portion of a month must be coded according to the nursing facility billing instructions
  - The nursing facility is not paid for the client's medical leave days
  - Code correctly to distinguish:
    - Days for which the nursing facility should be paid
    - Days for which days the hospital should be paid
- If the nursing facility bills per diem for days in the hospital:
  - The second claim processed will deny
  - The nursing facility must adjust its claim so the hospital can be paid

Medical Leave Days Example

Client is admitted to a hospital, but is expected to return

- To indicate medical leave days:
  - Use Value Code 81 with the number of days client in hospital
  - Use Revenue Code 185
- To indicate that client is expected to return:
  - Use Type of Bill (TOB) 223 or 623
  - Use Status Code 30 (still a patient)

Non-Medical Leave Days Example

Client leaves to visit family, but is expected to return

- Nursing facilities can be paid for 42 non-medical leave days per calendar year
  - Non-medical leave days **must** be approved by the client's physician
- To indicate paid non-medical leave days:
  - Use Revenue Code 182 for non-medical leave days
- To indicate unpaid non-medical leave days:
  - Use Value Code 81 with the number of non-covered days
  - Use Revenue Code 182 for non-medical leave days

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PARs Erroneously Ended

If a PAR is ended due to a facility mistakenly using a Type Of Bill ending in 1 or 4, using a discharge status code, or generating an Occurrence Code 42:

- Notify Ascend Management Innovations LLC (formerly DDM) to coordinate having the PAR reestablished
  - Phone: 1-877-431-1388
  - Fax: 1-877-431-9568

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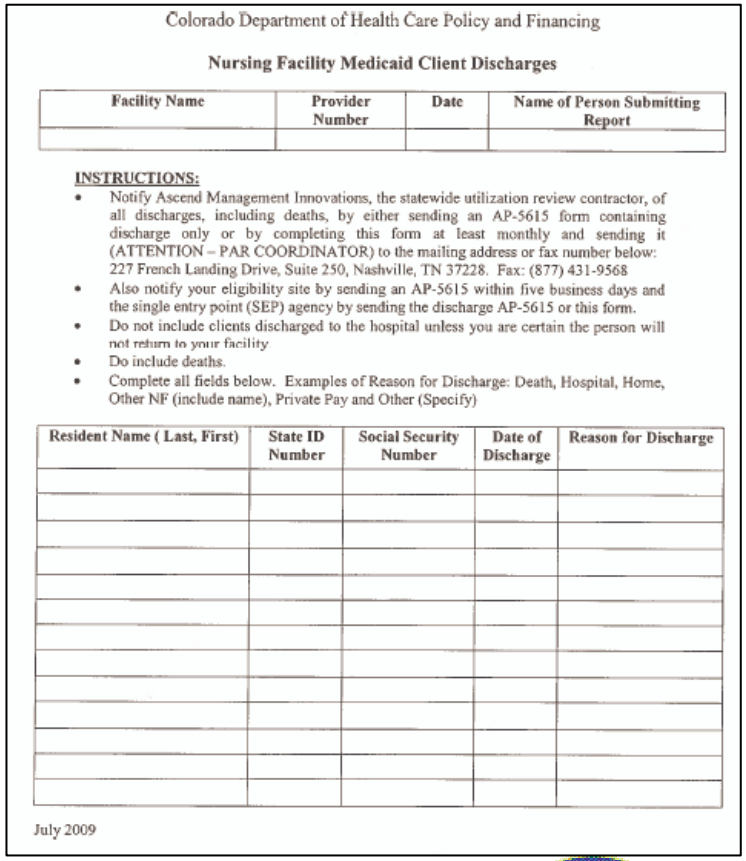
Discharge Forms

- Nursing Facility must report the discharge to Ascend, the Case Management Agency (Single Entry Point agency or Community Center Board), and the county
  - Nursing Facility Medicaid Client Discharges form: accepted by Ascend and the Case Management Agency (CMA)
  - AP-5615 form: accepted by the county and Ascend



Colorado Department of Health Care Policy and Financing

Nursing Facility Medicaid Client Discharges

Facility Name	Provider Number	Date	Name of Person Submitting Report

INSTRUCTIONS:

- Notify Ascend Management Innovations, the statewide utilization review contractor, of all discharges, including deaths, by either sending an AP-5615 form containing discharge only or by completing this form at least monthly and sending it (ATTENTION – PAR COORDINATOR) to the mailing address or fax number below: 227 French Landing Drive, Suite 250, Nashville, TN 37228. Fax: (877) 431-9568
- Also notify your eligibility site by sending an AP-5615 within five business days and the single entry point (SEP) agency by sending the discharge AP-5615 or this form.
- Do not include clients discharged to the hospital unless you are certain the person will not return to your facility.
- Do include deaths.
- Complete all fields below. Examples of Reason for Discharge: Death, Hospital, Home, Other NF (include name), Private Pay and Other (Specify)

Resident Name (Last, First)	State ID Number	Social Security Number	Date of Discharge	Reason for Discharge

July 2009

Discharge Reminders

If a client is discharged to another facility, to home, or death:

- The Type of Bill should end in 1 (221 or 621) or 4 (224 or 624)
- The Status Code should reflect the discharge
- Nursing Facility must report the discharge to Ascend, the Case Management Agency (CMA), and the county
  - Ascend end dates the PAR and sends the end date to ACS

Hospice Clients in a Nursing Facility

- ULTC 100.2 required if:
  - Medicaid eligibility for the hospice client is pending
  - Client's type of eligibility is HCBS
    - Required prior to the 30th day of the client not using HCBS services, which could be prior to 30 days in the nursing facility
    - In most cases, will not be required prior to admission
    - The Single Entry Point Agency (SEP) can verify when HCBS services will expire

Hospice Clients in a Nursing Facility

- ULTC 100.2 not required for admission if:
  - Client's eligibility type is NF and ULTC 100.2 is not expired
  - Client has a type of eligibility that will continue while in the nursing facility
    - Check with county or eligibility site to determine if types of eligibility (other than NF or HCBS) will require a ULTC 100.2

Hospice Clients in a Nursing Facility

- ULTC 100.2 will be required later if:
  - Client does not have active ULTC 100.2, leaves hospice status, and remains in the nursing facility
  - Client's eligibility type is NF and the ULTC 100.2 expires
    - Current ULTC 100.2 is required for annual eligibility redetermination

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Continued Stay Reviews

- Tracking ULTC 100.2 End Dates:
  - Official client length of stay end dates are on the ULTC 100.2 located on the certification page
    - Notify ACS with any errors on notification letter
    - Notify CMA of the need for re-certification at least 10 days before the length of stay end date
    - See the November 2006 Bulletin (B0600219) for more information

Colorado Medicaid
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Medicare Part A Claims

- Lower Of Pricing (LOP) is used to calculate reimbursement
- LOP compares Medicare paid amount to the Medical Assistance Program allowable amount
- Most claims will pay zero dollars
- Do not bill the client

Medicare Part A Claims

- The nursing facility can apply the patient payment to the Medicare co-insurance
- Exception is QMB (Qualified Medicare Beneficiary) client
  - QMB client retains patient payment amount

Medicare Part B Claims

- Reimbursement is made for coinsurance and deductible
- Supply claims may not be billed on the UB-04

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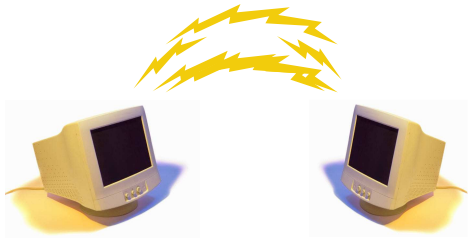
Crossover Claims – Automatic Process

Provider submits claims to Medicare.

Medicare transmits processed claims to Medicaid (ACS).

ACS processes the claims



Claims are finalized and successful crossovers appear on the Colorado Medical Assistance Program Provider Claim Report (PCR)

Crossovers may not happen if:

- NPI is not linked to CO Medical Assistance Program #
- Provider has not updated Medicare number
- Client is a retired Railroad employee
- Client has incorrect Medicare # on file

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Crossover Claims

- Medicare Part A crossover claims will be denied by the MMIS system and must be submitted by the provider
- If the Medicare Part B crossover claim does not appear on the PCR within 30 days of receiving the Explanation of Medicare Benefits (EOMB), the claim must be submitted by the provider
- You may submit crossovers electronically or on paper

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Crossover Claims – Provider Submitted

Web Portal Submission Process:

Provider receives Explanation of Medicare Benefits (EOMB)

Provider submits claim to Medicaid (ACS)

Claims are processed and appear on the Colorado Medical Assistance Program PCR

- Fill out all fields on the **Other Insurance Information Tab** in the Medicare Information section
- Choose **Medicare Only** to enable all the fields
- Retain the EOMB in your files

Colorado Medicaid
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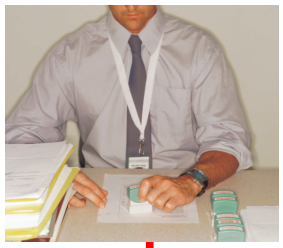
Crossover Claims – Provider Submitted

Paper Submission Process:

Provider receives Explanation of Medicare Benefits (EOMB)

Provider submits claim to Medicaid (ACS)



Claims are processed and appear on the Colorado Medical Assistance Program PCR

- Use Occurrence Code 50 or 51 and the date Medicare paid or denied
- Use Value Code B1 for deductible and/or B2 for coinsurance
- EOMB **needs** to be sent in with claim; retain copy for your files

Colorado Medicaid
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Other Resources

Commercial Insurance

- Commercial insurance must be billed first
- Lower of Pricing used to calculate reimbursement
- Provider may not bill the client for the difference
- Use correct 837I coding to indicate:
  - Insurance was denied
  - Other insurance paid
- If outside of timely filing, a delay reason code must be selected and a date must be noted in the "Claim Notes/LBOD" field

Colorado Medicaid
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Nursing Facility
Prior Authorization Request (PAR)

- Approved 5615 and ULTC 100.2 certification page constitute a PAR
  - Nursing Facility sends a referral to the CMA
  - CMA completes ULTC 100.2
  - Nursing Facility initiates 5615
  - County completes and approves 5615

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PARs

- After a facility receives its approved PAR documents (5615 and ULTC 100.2), the facility should verify the following:
  - The provider number
  - Start date
  - End date
  - Admit date
  - Demographics
  - 5615 is signed and dated by the County Medical Assistance Program office

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PARs

County Approval

Nursing Facility verifies information
and
Sends to Ascend (located in Tennessee)

Ascend transmits PARs to ACS

PARs

- The nursing facility sends the PAR documents to Ascend
- Ascend has 10 business days to complete the PAR
- Ascend transmits PARs to ACS daily
- 10 days after Ascend faxes the PAR Certification page to the nursing facility
  - The PAR should be in the Medical Assistance Program claims processing system and the nursing facility claims can be processed
- Additional information on the PAR process/ procedures can be found on Ascend's web site:
  Ascendami.com ▶ Colorado Tools ▶
  Colorado PAR/5615 Payment Process

NF PETI

- Nursing Facility Post Eligibility Treatment of Income (PETI)
  - Services that are not a Medicaid benefit may be approved under the NF PETI program if:
    - Medically necessary
    - Client has a patient payment amount
    - NF PETI is the payer of last resort

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NF PETI Process

- Nursing facilities can approve up to $400 in a calendar year for non-covered medically necessary services for non-hospice clients
- Nursing facilities shall retain copies of all supportive documentation relative to the first $400 PETI expense and all other PETI expenses for at least six (6) years for audit purposes
- NF PETI charges that must be submitted to the Department for authorization include:
  - Over $400 per calendar year
  - Hospice clients
  - **All** health insurance charges
  - Services not on the fee schedule

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NF PETI Request

NF PETI Request must include:

- Nursing Facility PETI Request form (NF PETI form)
- Medical Necessity Certification
  - With all required signatures
  - With all supporting documents
- Provider statement
- Provider's invoice
- Medicaid Program denial PCR (if applicable)
  - Providers must file a Medicaid claim for any service that is potentially a benefit of the Medicaid Program

Refer to: November 2006 Bulletin (B0600219)

Colorado Medicaid
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NF PETI

Send NF PETI requests that require authorization to the State:

Nursing Facility PETI Program

Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

April 2009

NF PETI Billing

- If a client has a medical trust, NF PETI charges must be paid from the medical trust
- Submit claims for approved NF PETI amounts on the claim with the client's room and board and patient liability amount
- The claims processing system automatically completes the calculations

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NF PETI Revenue Codes

Dental Services	969
Health Insurance Premiums and Other Services	999
Hearing and Ear Services	479
Vision and Eye Care	962

- Non-Medicaid participating providers may provide services for clients in nursing facilities

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NF PETI Fee Schedule

- See the June 2007 Bulletin (B0700234) for NF PETI Dental, Vision, and Hearing Fee Schedule
- Whenever a Medicaid fee schedule counters a published NF PETI fee schedule, the Department will rely on the Medicaid fee schedule

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Dental NF PETI

- Services must be medically necessary and not covered by the Medicaid Program (e.g. dentures)
- The facility, client, or the family determines the need for these non-Medicaid Program covered services
- Dental providers enrolled in the Colorado Medicaid Program should file an appropriately completed approved PAR and/or claim for:
  - Any dental service that is potentially a benefit of the Medicaid Program

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NF PETI Occurrence Span Dates

36	OCCURRENCE SPAN	
CODE	FROM	THROUGH
76	03/02/2009	03/12/2009

- Date(s) services rendered or insurance payments made
- No future dates
- May be same date in both fields
- Span dates do not have to fall within Statement Covers Period

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NF PETI

Nursing Facility PETI Services

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	129	Semi-Private	90.05		30	2701 50		1
2	479	Hearing and Ear Care			1	35 00		2
3	962	Vision Care			1	30 00		3

Enter approved amount paid to service providers

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NF PETI

Nursing Facility PETI Services

39		39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
	a	80	30 00				
	b	31	103 00				
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	129	Semi-Private	90.05		30	2701 50			1
2	479	Hearing and Ear Care			1	35 00			2
3	962	Vision Care			1	30 00			3

NF PETI Charges must be ≤ the patient payment entered for Value Code 31 (Patient Liability Amount)

Colorado Medicaid
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Nursing Facility Contacts

For NF PETI related questions not directly related to billing, please contact:

Susan Love at 303-866-4158

Colorado Medicaid
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Nursing Facility Rate Information on the Internet

- 4 levels of inquiry
- General and statistical info, forms, and helpful links available to anyone
- Individual facility information requires password issued to stand alone facilities
- Nursing facility "chains" access via group password, issued to common corporation or owners

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Notification of Redetermination

- Nursing facilities receive letters of client eligibility redetermination the 2nd week of the month (1 week after client receives redetermination packet)
  - Enables facility to offer assistance to reduce risk of client's eligibility being discontinued due to lack of response to redetermination
- Redeterminations are due the first of the following month, unless otherwise specified

Managed Care

Types of Managed Care include:

- Pre-paid Health Plans (PHPs)
- Primary Care Providers (PCPs)
- Behavioral Health Organizations (BHOs)

Prepaid Health Plan (PHP)

- Check client eligibility every month to determine if the client is in a PHP
  - Client could be passively enrolled in a PHP without nursing facility notification
  - May ask client/responsible party if PHP needs to be maintained while in the nursing facility
- Check with the PHP on which services are PHP benefits and which providers are required
  - PHP services **may** include the following: Ambulance, DME/Supply, Hospital, Physician Services, Lab & X-ray, and Vision

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Prepaid Health Plan (PHP) Billing

- If a service is a PHP benefit and PHP benefits **are not** exhausted:
  - Provider or nursing facility does not bill Medicaid fiscal agent
- If a service is a PHP benefit and PHP benefits **are** exhausted:
  - Bill on paper with a copy of the PHP denial
- If a service is **not** a PHP benefit:
  - Provider or nursing facility bills directly to the fiscal agent
- If the client is in a PHP, but PHP was not displayed on eligibility verification:
  - Bill on paper with a copy of the eligibility print out

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Primary Care Providers

- Check client eligibility to determine if client has a Primary Care Physician (PCP)
  - May ask client/responsible party if PCP needs to be maintained while in the nursing facility
- Prior to admission, get a referral from the PCP
  - Includes the physician's NPI and Medicaid numbers
- Indicate the PCP on claims:
  - UB-04 – Attending Physician ID field or Other Physician ID field if the attending physician is not the PCP

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Questions?

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Thank You!

Please help us by filling out a brief evaluation

Presenter: Eva Guerrero